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IN THE

Supreme Court of the United States

October Term, 1975
No. 74-1452

HOSPITAL BUILDING COMPANY,

Petitioner,

vs.

TRUSTEES OF THE REX HOSPITAL, a Corporation; JOSEPH BARNES, GEORGE STOCKBRIDGE, and RICHARD URQUHART, JR.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit.

MOTION OF FEDERATION OF AMERICAN HOSPITALS FOR LEAVE TO FILE BRIEF AS AMICUS CURIAE IN SUPPORT OF PETITIONER HOSPITAL BUILDING COMPANY

AND

BRIEF OF FEDERATION OF AMERICAN HOSPITALS AS AMICUS CURIAE IN SUPPORT OF PETITIONER HOSPITAL BUILDING COMPANY.

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Respondents.

Motion of Federation of American Hospitals for Leave to File Brief as Amicus Curiae in Support of Petitioner Hospital Building Company.

The Federation of American Hospitals (FAH) respectfully moves this Court for leave to file the accompanying brief as amicus curiae in support of petitioner Hospital Building Company (HBC). The consent of the attorneys for HBC has been obtained but the attorneys for respondents have refused to consent to the filing of a brief by FAH—as they did unsuccessfully in the Court of Appeals.

FAH, a non-profit corporation organized and existing under the laws of the State of New York, represents the interests of approximately 1,100 investor-owned acute care hospitals (including Mary Elizabeth Hospital

operated by petitioner HBC) throughout the United States and its possessions[1] by means of direct membership and affiliated state associations. FAH is the recognized spokesman for such hospitals.

FAH and its members have a direct and immediate interest in this case because the overwhelming majority of its members participate as providers of services in the Medicare program and, in addition, a substantial portion of FAH members are located in states which have enacted certificate of need legislation.[2] Therefore, most FAH members will ultimately be affected by this Court's decision.[3]

In this case the Court of Appeals for the Fourth Circuit held that the conduct alleged by petitioner was not within the ambit of section 1 of the Sherman

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[1]In 1974 there were 7,174 hospitals registered with the American Hospital Association. (AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS, at 3 (1975).) The overwhelming majority of hospitals in the United States are registered with the AHA.

[2]Generally, certificate of need legislation is designed to prevent duplication of facilities, services and equipment by requiring that each proposed construction or expansion of a health facility be allowed only upon a determination that the proposal meets a legitimate public need. (*E.g.*, Cal. Health & Saf. Code §§ 437 *et seq.*) Since 1966, the year in which Congress authorized the Secretary of Health, Education and Welfare (Secretary) to make grants to states which have adopted (and had approved by the Secretary) state plans for comprehensive health planning (42 U.S.C. § 246), twenty-seven states have enacted such legislation and three more are presently considering it. (Information obtained from the Department of Health Planning and Delivery of the American Hospital Association (as of December 31, 1974).)

[3]If the purpose of certificate of need legislation can be undermined by allowing persons to prevent or delay expansion of facilities after approval has been obtained, especially when such facilities are intimately involved in the flow of interstate commerce, then the adverse impact on the hospital industry, including the members of FAH, will be significant.

Act because it neither occurred in interstate commerce nor substantially affected it. In view of the setting in which today's hospitals operate, FAH believes that the Court of Appeals' decision was unrealistic and, therefore, incorrect.[4] Further, it left undisturbed the decision of the Court of Appeals which will render meaningless existing federal[5] and state certificate of need laws and will result in increased costs of hospital services.[6]

FAH desires to present to this Court certain facts which highlight the artificiality of the decision below and bring into clearer focus the impact of such facts on the issues before this Court. Specifically, such facts describe (a) the involvement of the Medicare program and the participating hospitals (including Mary Elizabeth) in interstate commerce, and (b) the relationship of present day hospital services to the flow of commerce to and from the hospital facility. Such facts have not been—and may not be—presented to this Court by the parties because petitioner has requested FAH to present them and respondents have no reason to do so since such facts serve only to weaken respondents' position.

In addition, FAH desires to present a succinct argument based on such facts, without duplicating any of the arguments made by respective counsel.

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[4]Although the decision also is in conflict with decisions in other circuits, this argument is being made by the parties herein; FAH, therefore, does not intend to duplicate such efforts.

[5]See 42 U.S.C. § 246.

[6]Congress has given additional impact to certificate of need laws by enacting a statute which requires the Secretary of Health, Education and Welfare to exclude from a health facilities' Medicare and Medicaid payments certain sums related to capital expenditures if prior approval for such expenditures was not obtained from a state planning agency. (42 U.S.C. § 1320a-1.)

As noted above, when this case was before the Court of Appeals FAH was allowed to file, over respondents' objection, an amicus curiae brief in support of petitioner. With this matter now before this Court, respondents have again objected to the filing of an amicus curiae brief by FAH. In a case of this magnitude this Court should have, to the greatest extent practicable, the benefit of a full airing of all the facts, issues and arguments involved. Viewed in this light, there is no apparent valid reason for respondents' opposition to the filing of an amicus curiae brief by FAH.

Accordingly, FAH respectfully requests permission to file the accompanying amicus curiae brief containing the items described in this motion.

Respectfully submitted,

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Brief of Federation of American Hospitals as Amicus Curiae in Support of Petitioner Hospital Building Company.

I. INTEREST OF AMICUS CURIAE.

The interest of amicus curiae is set forth in the preceding motion at pages 1-2, *supra.*

II. SUMMARY OF ARGUMENT.

The very existence of the Medicare program depends on the transfer of substantial sums of money between the government, intermediaries, carriers and hospitals located in every state of the Union; the services paid for with such funds are, therefore, an integral part of an interstate transaction. Moreover, given the substantial volume of interstate Medicare transactions, and the inseparability of hospital services from those transactions, a restraint on the provision of such services

sufficiently affects interstate commerce to invoke the provisions of the Sherman Act.

In addition, and apart from participation in the Medicare program, it is generally recognized in today's world that hospitals are intimately involved in interstate commerce. This recognition is manifested not only by federal labor laws and the cases construing them but also by other federal legislation which has an effect on hospital operations and which is based on the power of Congress to regulate commerce among the states.

III. ARGUMENT.

A. Introduction.

In this case the Court of Appeals for the Fourth Circuit held that the conduct alleged to have been engaged in by respondents, even had it occurred,[1] was of a nature which did not act directly upon activity in the flow of interstate commerce ("in commerce" test) and did not restrain activity having a substantial effect on interstate commerce ("affecting commerce" test). (Appendix to Brief of Petitioner (hereinafter "App.") at 57, 61; 511 F.2d at 682, 684.)

The basis for the Court of Appeals' holding on the "in commerce" test appears to be that (a) restraining the hospital services by Mary Elizabeth Hospital ("Mary Elizabeth"), owned by petitioner Hospital Building Company (HBC), and (b) controlling the market for such services in the Raleigh area did not act directly upon the interstate aspects of HBC's business but, rather,

[1]Hereinafter, the reference to such conduct as having been "alleged" will be omitted, recognizing that this case involves the question of whether the district court's dismissal on the pleadings was proper.

affected only the provision of surgical-medical services in the Raleigh area—a local, intrastate activity. (App. at 56-57; 511 F.2d at 682.)

As will appear more fully below, the conclusion reached by the Court of Appeals is unrealistic in view of the health care delivery system which presently exists in the United States. Today, conduct which affects the rendition of hospital services automatically affects the goods, services and activities which make the delivery of those very hospital services possible.

The bases for the Court of Appeals' holding on the "affecting commerce" test appear to be that (a) respondents' conduct did not have a sufficiently substantial effect on interstate commerce to satisfy the "affecting commerce" test (App. at 61; 511 F.2d at 684), (b) the effect of respondents' conduct on HBC was the result of the indirect and fortuitous consequence of the restraint of intrastate hospital services rather than the result of activity purposely directed toward interstate commerce (App. at 60; 511 F.2d at 684), (c) none of the economic consequences resulting from such restraint could have more than a negligible impact on their respective markets (App. at 61; 511 F.2d at 684), and (d) petitioner has made no allegation that respondents have the kind of anticompetitive power at which section 1 of the Sherman Act is aimed (App. at 64; 511 F.2d at 685).

As is further illustrated below, these observations by the Court of Appeals simply are not accurate. Because the operations of Mary Elizabeth, and hospitals like it, result in considerable involvement in interstate commerce, and because the provision of hospital services is inseparable from such interstate involvement, the effect of conduct which restrains the rendition of those

hospital services necessarily has a direct and substantial effect on interstate commerce. (*See Goldfarb v. Virginia State Bar*, ... U.S. ....., 95 S.Ct. 2004, 2012, 44 L.Ed.2d 572, 583-84 (1975).) This relationship is further highlighted by the fact that any noticeable restraint on the flow of goods, services or funds to Mary Elizabeth would seriously impede the delivery of such hospital services.

Finally, the Court of Appeals suggests that respondents do not have the kind of anticompetitive power which Congress sought to guard against. Such an analysis, however, overlooks the intent of the Sherman Act, which is to make unlawful certain kinds of anticompetitive *conduct*, not the threatened or actual *result* of that conduct. The fact that there has been no showing that petitioner was actually put out of business or that respondents had the power to do so, is immaterial. (*See id.*)

B. Operation of the Medicare Program Depends on Interstate Transactions.

1. The "in Commerce" Test.

Petitioner maintains that Mary Elizabeth's participation as a qualified provider of services under the Medicare program has resulted in its intimate involvement in interstate commerce. In order to illustrate the extent to which the Medicare program is involved in interstate commerce, a brief explanation of the mechanics of the program is necessary.

The Social Security Amendments of 1965, as amended, have been codified as 42 U.S.C. §§ 1395-1395pp (hereafter "Medicare Act" or "Act").[2] The Act provides

[2]Hereinafter, all references to sections are to Title 42 of the United States Code unless otherwise indicated.

basically two kinds of health insurance for its beneficiaries. Part A of the Act (§§ 1395c-1395i-2) generally provides insurance for services rendered by hospitals and other institutions (hereinafter sometimes referred to collectively as "providers") which are qualified to participate in the Medicare program. (§§ 1395f, 1395cc.)[3] Payment for services rendered by such providers is based on the reasonable cost of such services, which includes not only the cost of patient care (*e.g.*, drugs, medical supplies, food, nursing services, etc.) but also that portion of the provider's costs related to (a) depreciation on the provider's building and equipment and (b) interest on loans for construction of the building and purchase of the equipment allocable to such patient care. (§§ 1395x(v)(1)(A); 20 C.F.R. §§ 405.401-405.452; 1 CCH Medicare and Medicaid Guide ¶¶ 4590-5999X-15.) Payment is made by the Secretary of Health, Education and Welfare (Secretary) directly to qualified providers, or fiscal intermediaries located throughout the United States

[3]In 1974 there were 7,174 hospitals registered with the American Hospital Association. (AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS, at 3 (1975).) The overwhelming majority of hospitals in the United States are registered with the American Hospital Association.

Health Maintenance Organizations (§§ 300e *et seq.*) are also eligible to participate in the Medicare program. (§ 1395 mm.) As of October 1, 1974 there were 177 operational HMOs. (Schneider and Stern, *Health Maintenance Organizations and the Poor: Problems and Prospects*, 70 Nw. U.L. REV. 90, 91 n.2 (1975).) Some of the well-established HMO prototypes are: the Kaiser Foundation health plan in Oakland, California (est. 1942), the Ross-Loos Medical Clinic in Los Angeles (est. 1929), Group Health Association in Washington, D.C. (est. 1937), the Group Health Cooperative of Puget Sound (est. 1947), and the Health Insurance Plan of Greater New York (est. 1947). As of the end of 1972 about 7 million persons were enrolled in such plans. (2 CCH MEDICARE AND MEDICAID GUIDE ¶ 13,945, at 5676.)

nominated by such providers,[4] with monies from the Federal Hospital Insurance Trust Fund (§ 1395i).[5]

[4]The Medicare Act authorizes national, state or other public or private agencies or organizations, commonly known as "fiscal intermediaries" when operating under part A of the Act, to assist in the administration of the program.

Among other things, fiscal intermediaries process Medicare reimbursement claims received from providers by determining the amount of payment due to the providers on such claims for Medicare services and paying providers on such claims, consult with providers regarding the maintenance of their fiscal records, audit the records of such providers and serve as a channel of communication between the providers and the Secretary. (§ 1395h(a).) These fiscal intermediaries are usually private organizations such as health and accident insurance companies and the Blue Cross Association (which subcontracts with approximately 73 different Blue Cross plans throughout the United States). As of March 1974 intermediaries for part A of the Act and the states in which they serviced providers were: *Aetna Life and Casualty*—Alabama, Arizona, Arkansas, California, Connecticut, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Dakota, Tennessee, Texas, Virginia, Washington, and Wisconsin; *Blue Cross Association* (through 73 Blue Cross plans)—All States (including the District of Columbia and Puerto Rico) with the exception of Hawaii and Nevada; *Cooperativa de Seguros de Vida de Puerto Rico*—Puerto Rico and Virgin Islands; *Hawaii Medical Service Association*—Hawaii, American Samoa, and Guam; *Inter-County Hospitalization Plan, Inc.*—Pennsylvania; *Kaiser Foundation Health Plan, Inc.*—California, Hawaii, Ohio, Oregon, and Guam; *Mutual of Omaha Insurance Co.*—Alabama, California, Colorado, District of Columbia, Florida, Idaho, Illinois, Iowa, Kansas, Kentucky, Maryland, Michigan, Mississippi, Missouri, Montana, Nebraska, Oklahoma, Oregon, South Dakota, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin; *Nationwide Mutual Insurance Co.*—Kentucky and Ohio; *Prudential Insurance Co. of America*—New Jersey; *Travelers Insurance Co.*—California, Connecticut, Florida, Georgia, Illinois, Indiana, Maine, Massachusetts, Michigan, Minnesota, Montana, New Hampshire, New Mexico, New York, Pennsylvania, Rhode Island, Vermont, and Wisconsin. (2 CCH MEDICARE AND MEDICAID GUIDE ¶ 13,310, at 5357.) During fiscal year 1973 intermediaries processed almost 20 million part A bills. (Communication from Secretary of Health, Education and Welfare, Seventh Annual Report on Medicare Covering Fiscal Year 1973, at 1 (1975) [hereinafter "Annual Report"].)

[5]The Federal Hospital Insurance Trust is made up of compulsory wage taxes paid by employers, employees and

If a provider nominates a fiscal intermediary to assist it in its dealings with the Secretary, the provider's bills are submitted directly to the intermediary for payment. (§ 1395h(a).) Although a provider may choose to deal directly with the Secretary rather than through a fiscal intermediary (§ 1395h(a); *see also* 20 C.F.R. § 405.651(a)), all but a small percentage of providers have elected to deal with the Secretary through such intermediaries.[6]

The method of transferring funds from the Trust Fund to the fiscal intermediary, with slight variations in each case,[7] is generally by letter of credit. (*See* 31 C.F.R. § 205.5; Social Security Administration, U.S. Dept. of Health, Education and Welfare, Part A, Intermediary Manual—Part 1, Fiscal Administration (HIM 13-1) ¶¶ 1408-1410.) The managing trustee of the Trust Fund is required to pay to the Secretary such amounts as the Secretary certifies are necessary for the payments required under the Medicare program. (§ 1395i(h).) Letters of credit issued to intermediaries are first sent by the Social Security Administration to the Treasury Department for verification. Once veri-

self-employers under the Federal Insurance Contributions Act (FICA) and the Self-Employment Contributions Act. (*See* 26 U.S.C. §§ 1401(b), 3101(b), 3111(b).)

[6]About 1.5 percent of the national part A claims are submitted directly by providers. (Annual Report, *supra* note 4, at 12.) As of June 30, 1973 the Blue Cross Association (with subcontracts to 73 Blue Cross Plans), five commercial health insurers, and four independent insurers were operating as fiscal intermediaries on behalf of over 13,000 participating providers and 2,900 independent laboratories. Approximately 6,757 of those 13,000 providers are hospitals. (Note 12, *infra*.) There were 187 hospitals, 86 skilled nursing facilities, 257 home health agencies and three rehabilitation agencies submitting bills directly to the Social Security Administration. (Annual Report, *supra* note 4, at 12.)

[7]The precise method of transferring such funds and the manner of payment varies due to the difference in agreements between the Secretary and each intermediary.

fied, the letter of credit is sent to the branch of the Federal Reserve Bank in the district in which the intermediary is located. The intermediary then draws a payment voucher which results in the transfer to its account of the funds authorized by the letter of credit.[8] The intermediary makes payments to participating providers by drawing checks on its account.

Part B of the Act (§§ 1395j-1395w) is a voluntary health insurance program which provides coverage for supplementary medical services such as physicians' care, outpatient physical therapy, ambulance and home health services. (§§ 1395k, 1395x(s).) Persons eligible for these benefits must make monthly payments established by the Secretary (§ 1395r(b) and (c)); these premiums together with contributions from the federal government are placed into the Federal Supplementary Medical Insurance Trust Fund (§ 1395t) to pay for the benefits under part B. (§§ 1395*l*(a), 1395t(g).)

Generally, a person enrolled under part B may either pay for covered services and request reimbursement (§ 1395u(b)(3)(B)(i)) of 80% of the reasonable charge (§ 1395*l*(a)) or assign the right to reimbursement to the person providing the service, who can collect as an assignee (§ 1395u(b)(3)(B)(ii)).

As in part A, intermediaries are authorized to assist in the administration of part B, however under part

[8]The specific procedures to be followed with respect to such letters of credit are promulgated by the Commissioner of the Bureau of Government Financial Operations in the Treasury Fiscal Requirements Manual for Guidance of Departments and Agencies. (31 C.F.R. § 205.10.)

B they are referred to as "carriers". (§ 1395u.) Part B is administered largely through such carriers,[9] locat-

[9]One of the reasons that, to the extent possible, physicians are required to be paid through carriers stems from the fact that private insurers, group health plans and voluntary medical insurance plans have more experience in reimbursing physicians for reasonable charges for their services. As of June 30, 1973 there were 33 Blue Shield plans, 13 insurance companies, one independent health insurer and one State agency operating as carriers. (Annual Report, *supra* note 4, at 91.) They were as follows: *Alabama*—Blue Cross-Blue Shield of Alabama; *Alaska*—Aetna Life & Casualty; *Arizona*—Aetna Life & Casualty; *Arkansas*—Arkansas Blue Cross and Blue Shield; *California*—Counties of Los Angeles, Orange, San Diego, Ventura, San Bernardino, Imperial, San Luis Obispo, Riverside, Santa Barbara: Occidental Life Insurance Co. of California; Rest of State, Blue Shield of California; *Colorado*—Colorado Medical Service, Inc.; *Connecticut*—Connecticut General Life Insurance Co.; *Delaware*—Blue Cross and Blue Shield of Delaware; *District of Columbia*—Medical Service of D.C.; *Florida*—Counties of Dade and Monroe: Group Health Incorporated; Rest of State, Blue Shield of Florida, Inc.; *Georgia*—The Prudential Insurance Co. of America; *Hawaii*—Aetna Life & Casualty; *Idaho*—The Equitable Life Assurance Society; *Illinois*—Cook County: Illinois Medical Service; Rest of State, CNA Insurance; *Indiana*—Mutual Medical Insurance, Inc.; *Iowa*—Iowa Medical Service; *Kansas*—Counties of Johnson, Wyandotte: Blue Shield of Kansas City; Rest of State, Kansas Physicians Service; *Kentucky*—Metropolitan Life Insurance Co.; *Louisiana*—Pan-American Life Insurance Co.; *Maine*—Union Mutual Life Insurance Co.; *Maryland*—Counties of Montgomery, Prince Georges: Medical Service of D.C.; Rest of State, Maryland Blue Shield, Inc.; *Massachusetts*—Blue Shield of Massachusetts, Inc.; *Michigan*—Blue Shield of Michigan; *Minnesota*—Counties of Anoka, Dakota, Filmore, Goodhue, Hennepin, Houston, Olmstead, Ramsey, Wabasha, Washington, Winona: The Travelers Insurance Co.; Rest of State, Blue Shield of Minnesota; *Mississippi*—The Travelers Insurance Co.; *Missouri*—Counties of Andrew, Atchison, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Clay, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette, Livingston, Mercer, Nodaway, Pettis, Platte, Ray, St. Clair, Saline, Vernon, Worth: Blue Shield of Kansas City; Rest of State, General American Life Insurance Co.; *Montana*—Montana Physicians Service; *Nebraska*—Mutual of Omaha Insurance Co.; *Nevada*—Aetna Life & Casualty; *New Hampshire*—New Hampshire-Vermont Physician Service; *New Jersey*—The Prudential Insurance Co. of America; *New Mexico*—The Equitable Life Assurance Society; *New York*—Counties of

(This footnote is continued on next page)

ed throughout the United States, whose functions are similar to those performed by part A intermediaries.[10]

Bronx, Columbia, Delaware, Dutchess, Greene, Kings, Nassau, New York, Orange, Putnam, Richmond, Rockland, Suffolk, Sullivan, Ulster, Westchester: Blue Cross-Blue Shield of Greater New York; County of Queens: Group Health, Inc.; Counties of Livingston, Monroe, Ontario, Seneca, Wayne, Yates: Genesee Valley Medical Care, Inc.; Counties of Allegany, Cattaraugus, Erie, Genesee, Niagara, Orleans, Wyoming: Blue Shield of Western New York, Inc.; Counties of Albany, Broome, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Cortland, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Onondaga, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Steuben, St. Lawrence, Tioga, Tompkins, Warren, Washington: Metropolitan Life Insurance Co.; *North Carolina*—The Prudential Insurance Co. of America; *North Dakota*—Blue Shield of North Dakota; *Ohio*—Nationwide Mutual Insurance Co.; *Oklahoma*—Aetna Life & Casualty. Department of Institutions, Social and Rehabilitative Services; *Oregon*—Aetna Life & Casualty; *Pennsylvania*—Pennsylvania Blue Shield; *Rhode Island*—Blue Shield of Rhode Island; *South Carolina*—Blue Shield of South Carolina; *South Dakota*—South Dakota Medical Service, Inc.; *Tennessee*—The Equitable Life Assurance Society; *Texas*—Group Medical and Surgical Service; *Utah*—Blue Shield of Utah; *Vermont*—New Hampshire-Vermont Physician Service; *Virginia*—Counties of Arlington, Fairfax, City of Alexandria: Medical Service of D.C.; Rest of State, The Travelers Insurance Co.; *Washington*—Washington Physicians' Service; *West Virginia*—Nationwide Mutual Insurance Co.; *Wisconsin*—County of Milwaukee: Surgical Care-Blue Shield; Rest of State, Wisconsin Physicians Service; *Wyoming*—The Equitable Life Assurance Society; *Puerto Rico*—Seguros de Servicio de Salud de Puerto Rico; *Virgin Islands*—Seguros de Servicio de Salud de Puerto Rico; *American Samoa*—Hawaii Medical Service Assn.; *Guam*—Aetna Life & Casualty. (2 CCH MEDICARE AND MEDICAID GUIDE ¶ 13,320, at 5373.) During fiscal year 1973 carriers processed over 58 million claims for physicians' and other medical services. (Annual Report, *supra* note 4, at 1.)

[10]A brief description of the functions of part A intermediaries appears in note 4, *supra*. Carriers may also be required to determine compliance with utilization review requirements (§ 1320c *et seq.*), to assist providers in the development of procedures relating to utilization practices and to initiate or assist with other utilization review activities.

In addition, the manner of transferring funds to carriers is substantially the same as the method used with part A intermediaries.[11]

In view of the foregoing, it is apparent that the very existence of the Medicare program depends on an interstate transfer of funds which begins at the United States Treasury and ends after numerous transactions involving fiscal intermediaries, carriers, providers and beneficiaries located in every state of the Union.[12] During the 1974 fiscal year, over $11 billion was the subject of such transfers.[13]

It is also evident that the close economic relationships between out-of-state businesses and the hospitals with whom they deal on a frequent basis make it unrealistic to label the rendition of hospital services as a purely local activity. Rather, such interstate business transactions are an integral part of the services provided by such hospitals.

[11]As with part A intermediaries, the manner of payment varies with each contract, but the basic policy of the Secretary of the Treasury, as set forth in 31 C.F.R. § 205.5, is generally followed. (*See* Social Security Administration, U.S. Dept. of Health, Education and Welfare, Part B, Intermediary Manual—Part 1, Fiscal Administration (HIM 14-1) ¶¶ 4408-4410.) In addition, each contract must provide for advances of funds to the carrier for the purpose of making payments by it under the supplementary medical insurance program.

[12]The number of fiscal intermediaries and carriers participating in the program as of June 1973 are set forth in notes 4 and 9, respectively, *supra*. At the close of the 1973 fiscal year, there were 6,757 hospitals and over 20 million beneficiaries participating in the Medicare program. (Annual Report, *supra* note 4, at 45.)

[13]Worthington, *National Health Expenditures, 1929-74, U.S. Dept. of Health, Education, and Welfare*, 38 SOC. SEC. BULL. 7 (No. 2, Feb. 1974). It is estimated that in 1974 public and private health expenditures constituted approximately 7.7% of the gross national product. (*Id.* at 5.)

For example, a substantial portion of the funds received by petitioner come from the federal government, albeit paid by fiscal intermediaries and carriers. Upon the completion of the petitioner's proposed expansion, a considerable amount of these funds would have been transferred to out-of-state suppliers of items required for direct patient care (*e.g.*, drugs, food, etc.), out-of-state construction lenders,[14] vendors of hospital supplies and equipment,[15] and an out-of-state management company.[16] Since these elements of financing and supply are the interstate aspects of the provision of hospital services and such services depend on, and are inseparable from, such interstate activity (*see Goldfarb v. Virginia State Bar*, ... U.S. ...., 95 S.Ct. 2004, 2012, 44 L.Ed.2d 572, 583 (1975)), the provision of such hospital services is an essential part of an interstate transaction.[17]

[14]Petitioner alleged that the cost of its expansion would have exceeded $4 million which would have been financed by one or more loans with one or more lenders located outside North Carolina. In 1974, the construction costs of all hospitals registered with the American Hospital Association totaled over $3.8 billion. (AMERICAN HOSPITAL ASSOCIATION, CONSTRUCTION REPORT ON HOSPITALS (Vol. 19, No. 9. Sept. 1975).)

[15]Petitioner alleged that in 1972, excluding food and supplies for its kitchen, 80% of the $112,846.00 it spent for supplies for its radiology, medical laboratory and electrocardiology operations and its pharmacy were purchased from out-of-state vendors.

[16]Charter Medical Corporation, which has its principal office in Macon, Georgia, manages Mary Elizabeth for HBC. In 1972, HBC paid Charter $36,000.00 for its management services. As of July 1975 there were at least 32 hospital management companies in the United States which owned or operated approximately 480 hospitals located in states other than the one in which the management company was located. (FEDERATION OF AMERICAN HOSPITALS, DIRECTORY OF INVESTOR-OWNED HOSPITALS AND HOSPITAL MANAGEMENT COMPANIES, at 47-68 (1975).)

[17]Indeed, these interstate aspects of petitioner's business make the very provision of hospital services possible.

Relying on *Rasmussen v. American Dairy Association*, 472 F.2d 517 (9th Cir.), *cert. denied*, 412 U.S. 950 (1973), petitioner argued in the Court of Appeals that it had satisfied the "in commerce" test because respondents' conduct acted directly upon the flow of interstate commerce. The Court of Appeals rejected this argument, stating that this case was distinguishable from *Rasmussen* (where all but one of the ingredients used to manufacture the product which was the subject of the alleged restraint were manufactured out-of-state)[18] because in this case there was "no out-of-state product that was passed to patients in an economic transaction as a dominant ingredient of hospital services in the Raleigh area." (App. at 58; 511 F.2d at 683.) It is submitted that the Court's distinction is illusory and misleading.

Here, as in *Rasmussen*, there are a number of "ingredients" which originate out-of-state and which are used to "manufacture" or make available a "product" in the form of hospital services. Contrary to the view of the Court of Appeals, the dominant ingredients of hospital services in Raleigh originate from out-of-state.

In addition, it is inaccurate to say, as did the Court of Appeals, that the only out-of-state product sold by Mary Elizabeth is drugs. As set forth above, there are many out-of-state goods and services used by Mary Elizabeth, all of which comprise the component parts of the hospital services provided by it.[19]

[18]In *Rasmussen*, the Court held that the restraint on the intrastate sale of a filled-milk product acted directly upon the flow of interstate commerce because all but one of the ingredients from which the filled-milk product was manufactured were supplied from out of the state.

[19]It is interesting to note that the Court of Appeals concedes that drugs are an inseparable component of the

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Finally, the Court of Appeals, relying on *Northern California Pharmaceutical Ass'n v. United States,* 306 F.2d 379, 386-87 (9th Cir.), *cert. denied,* 371 U.S. 862 (1962), stated that because the items flowing from out-of-state to Mary Elizabeth lose their character as both a product and a distinct line of commerce, the hospital services rendered by it were not part of interstate commerce. The Court's reliance is misplaced, not only because *Northern California* contains no requirement that out-of-state goods and services maintain their character as a product or as a distinct line of commerce, but also because the questions before the Court in *Northern California* simply are not analogous here.

In *Northern California* a pharmaceutical association and one of its members were convicted of violating section 1 of the Sherman Act for entering into an agreement to fix the price of precompounded prescription drugs shipped into California from outside the state. One of the contentions on appeal was that even though the drugs started out in the flow of interstate commerce, they were taken out of the flow before they reached consumers by being placed on the pharmacies' storage shelves. In observing that " 'commerce among the states was not a technical legal conception, but a practical one, drawn from the course of business' " (306 F.2d at 387), the court stated that there was a "practical continuity of movement" and the flow of commerce, therefore, did not stop at the pharmacies' storage shelves.

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services provided by Mary Elizabeth yet was not willing to concede that any of the other goods or services played the same role. (Appendix to Brief of Petitioner, at 58; 511 F.2d at 683.)

Thus, in *Northern California* it was uncontested that the drugs were part of the flow of commerce; the only question in the context of foregoing discussion by the Court of Appeals was whether such flow had stopped at the pharmacies' storage shelves. Here, the question in the first instance is whether the hospital services are a part of interstate commerce.

Accordingly, because petitioner's hospital services are in the flow of interstate commerce, the "in commerce" test clearly has been met.

2. The "Affecting Commerce" Test.

In applying the "affecting commerce" test the Court of Appeals concluded that the economic consequences of respondents' conduct would have no more than a negligible impact on interstate commerce. Unfortunately, none of the cases on which the Court relies gives any real support for its conclusion. In addition, the Court's dissatisfaction with the application of the test's standards was apparent:

> "Labeling one case 'de minimis' and another as 'affecting commerce' does achieve a result but is not otherwise very revealing. Anyone who studies decisions applying the 'affecting commerce' test will be struck by the absence of a clear line, much less a bright one, between those effects that are deemed substantial and those that are characterized as 'indirect,' or 'fortuitous,' or 'insubstantial,' or 'de minimis,' or 'sporadic,' or 'incidental.' In any area so very gray it is absurd to suppose that we or any other court can precisely count up the tons of plaster, bottles of liquor, or quantity of proprietary drugs sufficient to cross the line of substantiality. Increasingly, intrastate

economic conduct affects interstate commerce due to the interdependence of all segments of our national economy. Whether or not 'de minimis' has ever been an effective litmus for application of the Sherman Act, we doubt that it now is, and we are concerned that conventional impact analysis may sometimes conceal rather than reveal the true rationale of the decision." (App. at 62; 511 F.2d at 685.)

In addition, the Court of Appeals suggested that the difference between this case and *Doctors, Inc. v. Blue Cross of Greater Philadelphia*, 490 F.2d 48 (3d Cir. 1973) "may be not so much the quantitative difference in effect on interstate commerce as the dramatic difference in anticompetitive *power*." (App. at 64; 511 F.2d at 686; emphasis in original.) However, HBC should not be required to show that respondents had the anticompetitive power to put it out of business, since such an analysis focuses on the degree of impact, or result, of such anticompetitive conduct rather than the conduct itself (*see Goldfarb v. Virginia State Bar*, ... U.S. ....., 95 S.Ct. 2004, 2012, 44 L.Ed.2d 572, 583-84), which is the real danger Congress sought to guard against. As this Court recently stated in *Goldfarb:*

> "The fact that there was no showing that homebuyers were discouraged by the challenged activities does not mean that interstate commerce was not affected. Otherwise, the magnitude of the effect would control and our cases have shown that, once an effect is shown, no specific magnitude need be proved." (.... U.S. ...., 95 S.Ct. 2004, 2012, 44 L.Ed.2d 572, 583-84.)

It is therefore apparent from the foregoing analysis that petitioner also has satisfied the "affecting commerce" test; by restraining the expansion of hospital services which are an integral part of interstate commerce, respondents' conduct necessarily had a direct effect on interstate commerce.[20] (*See Goldfarb v. Virginia State Bar, supra,* ..... U.S. ....., 95 S.Ct. 2004, 2012, 44 L.Ed.2d 572, 583.)

C. Hospitals Are Now Recognized as Having Substantial Involvement in Interstate Commerce.

Wholly apart from their involvement in the Medicar. program, it is generally recognized that modern hospitals play an important part in commercial intercourse among the states. Examples of such recognition appear in the form of recent amendments to the National Labor Relations Act (29 U.S.C. §§ 151 *et seq.*) and other pieces of comprehensive legislation which affect hospitals throughout the United States.

1. The National Labor Relations Act.

It is well settled that enactment of the National Labor Relations Act of 1935 (NLRA) was within the power of Congress to regulate commerce among the states. (29 U.S.C. § 151; *National Labor Relations Board v. Reliance Fuel Oil Corp.*, 371 U.S. 224, 225-226, 83 S.Ct. 312, 313, 9 L.Ed.2d 279, 280-81 (1963); *Polish National Alliance, Etc. v. National Labor Relations Board*, 322 U.S. 643, 647, 64 S.Ct. 1196, 1198, 88 L.Ed. 1509, 1514 (1944); *National Labor Relations Board v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 30-31, 57 S.Ct. 615, 621, 81 L.Ed. 893,

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[20]It should also be noted that hospitals treat persons who themselves cross state lines.

907-08 (1937).) The National Labor Relations Board (NLRB), therefore, has the jurisdiction to mediate labor disputes affecting interstate commerce. (29 U.S.C. § 160(a).)

Prior to 1974 it was generally recognized that the NLRB had jurisdiction over investor-owned hospitals and investor-owned and non-profit nursing homes because of the impact of their operations on interstate commerce. In *Butte Medical Properties,* 168 N.L.R.B. 266 (1967), for example, the NLRB was required to decide whether it could properly assert jurisdiction over an investor-owned hospital which met the Board's standard of gross revenues required for the exercise of such jurisdiction, the employer arguing that the hospital had an insufficient impact on commerce to warrant the assertion of such jurisdiction. After a comprehensive analysis of all facets of the operations of the hospital in question (*e.g.*, use of out-of-state labor, various kind of supplies, equipment, insurance, utilities and participation in the Medicare and Medicaid programs), and the hospital industry in general,[21] the

[21]The Board's analysis was, in pertinent part, as follows:

"There is no dispute that while all hospitals are primarily humanitarian facilities, some aspects of their operations are essentially business in character. Operationally they are a multibillion dollar complex and, as such, comprise one of the largest industries in the United States. An effective part of this complex is composed of the approximately 970 proprietary hospitals which, as the record shows, influence and affect commerce beyond their immediate individual confines. While it is generally true, as the Employer and its proponents argue, that hospitals such as the Employer's are 'local' in that most of their medical staffs and patients come from nearby communities, that is not true with regard to difficult-to-secure personnel such as registered nurses, dieticians, and therapists. They often must be recruited from other areas. Nor are they local in the character of their operations since the present size and projected future growth of these hospitals indicate that their impact on commerce is already substantial and, in all likelihood, will become more so in the future. The facts show that despite a decrease in the number of proprietary hospitals in the last 20 years, these facilities are presently located in 44 States and, in fact, are an increasing part of the hospital industry in that, with fewer such hospitals, there has been a substantial increase in the number of beds, admissions, census, personnel, payroll, assets, and gross revenues which, in 1965, exceeded $551,000,000.

"The operations of these facilities, moreover, necessarily include substantial purchases of food, beverages, china, silverware, linens, furniture, drugs, medication, supplies and equipment, utility services such as heat, light, and power, as well as various types of insurance. While the purchases made by a particular proprietary hospital may not directly involve interstate commerce, the aggregate purchases of all such facilities clearly have a substantial impact on the operations of the various supplying industries and involve substantial shipments of goods and supplies in interstate commerce. The Employer's operation alone, for example, discloses yearly out-of-state purchases in excess of $30,000.

"Apart from the impact on commerce occasioned by the purchases of supplies and materials, there is also the financial interstate impact of billions of consumer dollars expended by millions of Americans for health protection and care, which dollars travel to and from national insurance companies and the Federal Government which, in turn, make payments directly or indirectly to proprietary and other hospitals. The extent of national participation in health insurance benefits is indicated by a Department of Health, Education, and Welfare report showing that as of December 31, 1964, 79.2 percent of the United States civilian population were enrolled for health care benefits by private health insurance companies, viz., 62,429,000 in Blue Cross and Blue Shield, 104,230,000 in various insurance companies, and 6,960,000 in independent programs. An indication of the amounts received by proprietary hospitals for such health care is shown by the Employer's operation which obtained fifty percent of its $1,100,000 gross revenue from various national health insurance agencies.

"Moreover, the material effect on commerce resulting from the nationwide individual expenditures for health care in which proprietary hospitals participate is further multiplied and augmented by the numerous public health

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Board concluded that the hospital did have a sufficient

impact on interstate commerce to warrant the assertion of its jurisdiction.[22]

On the same day the Board decided *Butte*, it ruled in *University Nursing Home, Inc.*, 168 N.L.R.B. 263 (1967), that the operations of an investor-owned nursing home had a similar impact on interstate commerce.

Similarly, in 1970 the Board concluded in *Drexel Home, Inc.*, 182 N.L.R.B. 1045 (1970), that the opera-

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and welfare enactments of Congress which are financed by the expenditure of public funds in which these facilities also participate, directly or indirectly. These concepts are manifest in the national Medicare program, which has a first year operating budget in excess of $2 billion and which provides for the payment of medical and hospital services to proprietary hospitals, including the Employer, as well as others, for the benefit of a large segment of our population. All of the foregoing unquestionably evinces a substantial national interest in, and a vital concern for, public health and welfare which, if affected by unregulated labor disputes in proprietary hospitals, would exert or tend to exert a wholly undesirable impact not only on the suppliers of these institutions, but also on the public, and, inevitably, on interstate commerce. We believe that these numerous private and public health care efforts *have a very substantial effect on interstate commerce* and that the public interest would be served by making available the orderly and peaceful procedures of this Act in the hospital industry. Indeed, concomitant with these particular efforts is the recognition in Sections 1(b), 201(a), and 206 of the National Labor Relations Act itself that the Act's policy of engendering stable industrial relations is based on advancing the health, safety, and general welfare of the Nation. *Therefore, in view of the substantial interstate and national impact on commerce which is exerted by the Employer and by proprietary hospitals generally, it is apparent that these institutions are not insulated local enterprises.*" (Emphasis added; footnotes omitted.)

[22]The Board's jurisdiction to mediate disputes concerning wages, hours and working conditions in the hospital industry is not insubstantial. In 1974 over 2.9 million persons were employed in the 7,174 hospitals registered with the American Hospital Association. The total payroll for such hospitals was over $23.8 billion. (AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS, at 3 (1975).)

tions of a non-profit home for the aged substantially affected interstate commerce.

Because *Butte, University* and *Drexel* were decided when the number of hospitals and nursing homes in the United States was substantially less than it is today, and at a time when the Medicare and Medicaid programs were relatively new, the rationale of these cases applies *a fortiori* to the instant interstate commerce analysis.

The courts have also recognized the impact of health care institutions on interstate commerce, some citing *Butte*, and some not. (*E.g., Doctors, Inc. v. Blue Cross of Greater Philadelphia*, 490 F.2d 48, 52 (3d Cir. 1973); *Glen Manor Home for Jewish Aged v. N.L.R.B.*, 474 F.2d 1145, 1148 (6th Cir.), *cert. denied*, 414 U.S. 826 (1973); *Council 19, American Fed. of State, Co. & Mun. Emp. v. N.L.R.B.*, 296 F.Supp. 1100, 1104 n. 4 (N.D. Ill. 1968).)

In 1974, recognizing the validity of these and other decisions by the NLRB and the courts, Congress amended § 183 of the NLRA to give express statutory recognition of the Board's jurisdiction to mediate labor disputes affecting *all* health care institutions (defined by § 152(14) as, among other things, any hospital, health maintenance organization or other institution devoted to the care of sick or infirm persons). It is therefore apparent that Congress considers hospitals and other types of health care institutions as being involved in interstate commerce to a degree sufficient to invoke its power under the commerce clause.

Since the ambit of the Sherman Act is at least as extensive as the NLRA, because the power to enact each is found in the commerce clause (*see Burke v. Ford*, 377 F.2d 901, 904 (10th Cir.) *rev'd on other grounds*, 389 U.S. 320, 88 S.Ct. 443, 19 L.Ed. 2d 554 (1967)), then hospitals should be considered as having a sufficient impact on interstate commerce under both Acts.

2. Comprehensive Legislation Affecting Hospital Operations.

Congress has enacted numerous pieces of legislation which regulate, in varying degrees, the operations of Mary Elizabeth and every other hospital in the United States. (*E.g.*, Occupational Safety and Health Act (29 U.S.C. §§ 651 *et seq.*); the Hazardous Substance Act (15 U.S.C. §§ 1261 *et seq.*); the Federal Food, Drug and Cosmetic Act (21 U.S.C. §§ 301 *et seq.*); the Drug Abuse Prevention and Control Act (21 U.S.C. §§ 841 *et seq.*).) The basis for enacting these laws was Congress' power to regulate commerce among the states. (*E.g.*, Occupational Safety and Health Act (29 U.S.C. § 651); Hazardous Substances Act (15 U.S.C. § 1263); Federal Food, Drug and Cosmetic Act (*United States v. Walsh*, 331 U.S. 432, 67 S.Ct. 1283, 91 L.Ed. 1585 (1947)); Drug Abuse Prevention and Control Act (21 U.S.C. § 801).) The fact that such hospital operations have come within the grasp of laws which find their genesis in the commerce clause lends further support to the proposition that modern day hospitals which deliver health care services are engaged in interstate commerce.

IV. CONCLUSION.

The delivery of hospital services by Mary Elizabeth, and the overwhelming majority of hospitals in the United States, is an integral part of an interstate transaction; moreover, a restraint on the provision of such services affects interstate commerce to a degree sufficient to invoke the provisions of section 1 of the Sherman Act.

The decision below should be reversed and the cause remanded for a trial on the merits.

Respectfully submitted,

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